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ABSTRACT

The relationship between the nonspecific factors of therapeutic alliance and motivation with outcome has been demonstrated across treatment modalities, and specifically in the treatment of alcohol dependence. The present study was designed to evaluate the association of these factors with treatment outcome in a preliminary sample of problem drinking men-who-have-sex-with-men and engage in unsafe sex. It hypothesized a positive association between therapeutic alliance and percentage of session attendance; and positive associations between three self reported motivational statements for alcohol, unsafe sex, and session attendance. Fifty-five participants enrolled in a clinical trial to reduce alcohol intake and unsafe sex were included in the study. Contrary to expectations, a positive association was not found between alliance and outcome. Among the motivational statements, only the readiness to change for alcohol was correlated with outcome. The stability of self efficacy and risk assessment across alcohol and sexual behaviors may suggest that these motivational statements represent a more stable trait than can generalize across behaviors. Findings are consistent with the notion that change in one's self efficacy or risk assessment for one behavior may result in changes in motivation for another behavior. (Author/JDM)

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Nonspecific factors in alcohol and unsafe sex treatment

The relationship between the nonspecific factors of therapeutic alliance and motivation with outcome has been demonstrated across treatment modalities (Horvath & Symonds, 1991), and specifically in the treatment of alcohol dependence (Conners, Carroll, DiClemente, Longabaugh & Donovan, 1997; Miller & Heather, 1998). The present study was designed to evaluate the association of these factors with treatment outcome in a preliminary sample of problem drinking men-who-have-sex-with-men (MSM) and who engage in unsafe sex (Morgenstern et al, 1998). We expected: 1) a positive association between therapeutic alliance and percentage of session attendance; and 2) positive associations between three self-reported motivational statements for alcohol and unsafe sex (i.e. readiness for change; self-efficacy; and risk assessment) and session attendance.

Method

Participants

Fifty-five participants who have been enrolled thus far in clinical trial to reduce alcohol intake and unsafe sex were included in the present study (Morgenstern et al., 1998). Twenty-three participants were randomized to four sessions of Motivational Enhancement Therapy (MET); twenty-three to twelve sessions of Cognitive Behavioral Risk Reduction Treatment (CBRRT); and nine to two, three or four sessions of feedback only. The mean age was 35.96 years (SD=7.89), and the ethnic composition included 19 African-Americans (34.5%), 9 Latinos (16.4%), 23 Caucasians (41.8%), and 4 (7.3%) classified as "other." Twenty-four participants (43.6%) were employed full time; 19

(34.5%) part-time; and 12 (21.8%) were unemployed. Forty-five participants (81.8%) self-identified as gay, and 10 (18.2%) as bisexual.

Instruments

Therapeutic alliance was measured with a short version of the Working Alliance Inventory (WAI; Horvath & Greenberg, 1986). This measure consists of twelve items that tap agreement on tasks and goals, as well as the affective bond between the therapist and client. Items are rated by both the therapist and the client following each session on a Likert scale (1-7), and total alliance scores are generated by adding all items. In this study, ratings after session one were included, as early ratings have been shown to predict outcome (Luborsky et al.,1983).

Motivation was assessed at intake with three questions for both alcohol and unsafe sex, i.e. How important is your change goal? (readiness for change) How successful do you expect to be in achieving your goal? (self-efficacy) How risky is your goal? (risk assessment). Participants responded to each question on a Likert scale (0-10).

Percentage of session attendance was computed to account for differences in treatment length between Motivational Enhancement Therapy (4 sessions), Feedback only (2-4 sessions) and CBRRT (12 sessions).

Procedure

Participants completed the motivational statements at intake, and after the initial therapy or feedback session, both clients and their therapists completed the WAI separately. The number of sessions attended was coded following treatment completion.

Results

There were no significant differences in mean alliance by client or therapist nor in any of the motivational statements for alcohol or sex between CBT and MET conditions.

While the alliance ratings by client were highly correlated with therapist ratings ($r = .56$, $p < .01$), the total mean alliance as rated by the clients ($M = 73.18$, $SD = 10.25$) was significantly higher ($t = 7.84$ (54), $p < .01$) than therapist ratings ($M = 60.69$, $SD = 14.01$). However, there were no significant correlations between alliance ratings, whether by the client or therapist, and the percentage of sessions attended.

There was a significant positive correlation between readiness to change for alcohol and percentage of sessions attended ($r = .28$, $p < .05$). None of the remaining motivational statements were correlated with outcome.

Among the motivation statements, self-efficacy statements were consistent between alcohol and sex ($r = .43$, $p < .01$); and risk assessment statements were also consistent between alcohol and sex ($r = .42$, $p < .01$). As expected, risk assessment and self-efficacy were negatively correlated for alcohol ($r = -.35$, $p < .01$), but not for sexual behaviors.

Finally, while readiness to change was not correlated with self-efficacy for alcohol, these statements were significantly correlated for sex ($r = .67$, $p < .01$).

Discussion

Contrary to expectations, we did not find a positive association between alliance and outcome as assessed in this study. This may be due to the relatively small sample size, the restricted range in client alliance ratings, and the difficulty in standardizing the

measurement of outcome by session attendance across three treatment conditions with different treatment length requirements.

Among the motivational statements, only the readiness to change for alcohol was correlated with outcome; that is, the more participants believed that their goal of reduced drinking was important, the more likely they were to complete treatment.

Interestingly, the stability of self-efficacy and risk assessment across alcohol and sexual behaviors may suggest that these motivational statements represent a more stable trait that can generalize across behaviors. Moreover, these findings are consistent with the notion that change in one's self-efficacy or risk assessment for one behavior may result in changes in motivation for another behavior.

As these are preliminary data derived from the early months of an ongoing clinical psychotherapy trial, the results reported here are tentative. If, however, the findings of a positive association between readiness to change at intake and outcome are replicated with a larger sample, they would suggest that participants at risk for treatment dropout can be identified as early as intake, and that interventions aimed at modifying the perceived importance of change may preclude dropout. This may be especially useful in the treatment of this population on whom treatment process and outcome data are largely unavailable.

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